REVITALIZE
PHYSICAL THERAPY

New Patient Registration

PATIENT INFORMATION

First Name_____ MI_____ Last Name_____ ❍ Male ❍ Female

Date of Birth_____/_____/_____ Age_____ Social Security Number _____-_____-_____

Marital Status: ❍ Single ❍ Married ❍ Widowed ❍ Divorced ❍ Spouse/Partner Name _____

Home Address_____ PO Mailing Address [if applicable] _____

City_____ State_____ Zip _____ email (print)_____

Primary Contact number: ❍ Cell ❍ Home (Provide TWO contact numbers)

Cell _____ Home _____ Work _____ Other _____

Preferred Language: ❍ English ❍ Spanish ❍ Other _____

Patient Occupation_____ Employer Name_____

Employer Address_____

Emergency Contact Name_____Ph#_____Relationship_____

***If the patient is a minor** – name of parent(s) or guardian _____

Address (if different from patient) _____ Cell_____ Other Ph # _____

PAYMENT AND INSURANCE INFORMATION

❍ Self-Pay (*Our Practice is not a Medicaid provider and cannot bill Medicaid)*

PRIMARY insurance _____ Full Name of Insured _____ Relationship to Patient_____

Insured Date of Birth (Required) _____ Insured SSN_____-_____-_____

Insured Employer _____ Address_____

SECONDARY insurance _____ Full Name of Insured _____ Relationship to Patient_____

REFERRAL INFORMATION

How did you hear about our office?

❍ Doctor Name_____ Ph #_____

❍ Family Member ❍ Friend Name_____ Address_____

❍ Google ❍ Newspaper ❍ Saw our Sign ❍ Insurance Plan ❍ Our Website ❍ Radio ❍ Hospital

❍ Facebook Yorkville Group ❍ Facebook ❍ Instagram ❍ Other _____

CONSENT FOR PHOTOGRAPHY, VIDEOTAPING, OR OTHER IMAGING FOR MEDIA OR EDUCATION PURPOSES

I willingly give authorization and consent to Revitalize Physical Therapy to use photographs, videotaped images, or other images of myself for the purpose of teaching (including other patients), advertisement on social or print media, and placement on our Revitalize Physical Therapy website.

_____ _____ _____

Signature of patient/legal representative | date | If legal representative, relationship to patient

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MEDICAL HISTORY

Do you drink? ❍No ❍ Yes Drinks per week _____

Do you smoke? ❍No ❍ Yes Packs per day _____

Have you ever had any of the following **foot conditions**?

Please check all which apply:

- ❒ Ankle Instability
- ❒ Arthritis
- ❒ Back Pain
- ❒ Blisters
- ❒ Bone Spurs
- ❒ Bunions
- ❒ Burning Feet
- ❒ Corns/Calluses
- ❒ Diabetic Evaluation
- ❒ Flat Feet
- ❒ Fracture
- ❒ Fungal Infections (skin/nail)
- ❒ Gout
- ❒ Hammertoes
- ❒ Heel Pain
- ❒ Hip Pain
- ❒ Infections
- ❒ Ingrown Toenails
- ❒ In Toe – Out toe walking
- ❒ Joint Pain
- ❒ Knee Pain
- ❒ Limb Length Discrepancy
- ❒ Neuromas
- ❒ Numbness/tingling in foot or toes
- ❒ Plantar Fasciitis
- ❒ Postural Fatigue
- ❒ Pronation
- ❒ Shin Splints
- ❒ Sprains
- ❒ Sweating/Odor
- ❒ Tendonitis
- ❒ Tired feet
- ❒ Ulcers
- ❒ Warts

Have YOU ever been treated for any of the following conditions?

Please enter ✓ if it applies to **YOU**

Enter **M** if on your birth mother's side; **F** on your birth father's side

- _____Acid Reflux
- _____Anemia
- _____Arthritis
- _____Asthma
- _____Bleeding Disorders
- _____Cancer
- _____Depression
- _____Diabetes
- _____Epilepsy
- _____Fatigue
- _____Fibromyalgia
- _____Headaches
- _____Heart Condition
- _____Hepatitis
- _____High Cholesterol
- _____HIV/AIDS
- _____Hypertension
- _____Hyperthyroidism
- _____Hypothyroidism
- _____Irritable Bowel Syndrome
- _____Kidney Problems
- _____Liver Disease
- _____Low Blood Pressure
- _____Nervous Disorder
- _____Muscle or Joint Pain
- _____Peripheral Arterial Disease
- _____Parkinson's Disease
- _____Phlebitis
- _____Poor Circulation
- _____Respiratory Disease
- _____Rheumatic Fever
- _____Shortness of Breath
- _____Seizure Disorders
- _____Stomach Ulcers
- _____Stroke
- _____Varicose veins

ALLERGIES

Have you ever had any ADVERSE side effects, rash, allergic reaction to:

	YES	NO		YES	NO
Adhesive tape			Metal/Jewelry		
Anticoagulants			Nickel		
Anti-inflammatory meds			Novocain		
Aspirin			Peanuts		
Codeine			Penicillin		
Cortisone			Seafood		
Iodine			Other antibiotics		
Latex			Other pain medication Other _____		

Height _____' _____" Shoe Size_____

Please list all surgeries **Please use the back of this page if needed**	**Approximate Date**

MEDICATIONS

Provide a printed list or enter below

Are you currently on Blood Thinners? Yes ❍ No ❍

Medication	Dose

FAMILY / PRIMARY CARE PHYSICIAN

Name: _____

Phone: _____

PHARMACY

Name:_____

Address required: _____

Phone: _____

CONSENT for Treatment/Authorization for Payment

I consent to examination, treatment and other services provided by the doctors, their associates, or physical therapy staff. I authorize Centers for Foot & Ankle Surgery, Ltd. to release to my insurance company or its representatives, any information regarding my diagnosis or records of treatment or examination rendered to me required to process my claims.

I authorize and request my insurance company pay Centers for Foot & Ankle Surgery, Ltd. directly the amount due me in pending claims for medical treatment or services, by reason of such treatments or services rendered to me until revoked in writing. I understand I am directly responsible for services rendered and not paid by insurance.

I understand the information provided on this form is true and correct to the best of my knowledge.

Patient Signature_____

Date _____If not patient, relationship _____

Financial Policy Agreement

We participate in most insurance plans, including Medicare. It is the patient's responsibility to ensure we are a participating provider in your insurance network. **We are not participating providers for any Medicaid government plans**. If you are not insured by a plan we participate with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments/deductibles: Due on the date of service. Services **not** covered by the patient's insurance will become the patient's responsibility.

Cancellation/No show fees: We require a minimum of 24-hour notice to avoid:

- $50 missed office visit
- $50 for Physical Therapy appointments
- $150 for scheduled in-office procedures – *Requires 48-hour notice*
- $250 Scheduled Surgeries at a hospital or surgical center – *when made less than 7 business days before the scheduled appointment day.*

Balances: (patient balance not insurances)

- **Balances will accrue a $15 Service/Late Fee per month** after 60 days.
- We offer *Care Credit* for monthly payments. (*no/low interest* between 6-24 months if you qualify).
- Unpaid balances may be referred to our collection agency.

Fees for Paperwork: Disability, FMLA, Workman's Compensation, other forms: Fees ***start*** at $10

Medical Record Copies: Fees are assessed according to Illinois law. Di*gital X-rays*: $5

Please ensure our practice has:

- A copy of a currently active insurance card and a valid photo ID. Failure to provide us with the correct insurance information will require us to transfer the balance to you.
- HMO: the patient is responsible for requesting and providing us with a referral.
- If your insurance changes, you must notify us before your next visit.

Claims submission: We will submit your claims and assist you in getting your claims paid. Your insurance company may need certain information directly from you, and it is your responsibility to comply with their request.

Please sign below to indicate you have read and understand our financial policy.

_____ _____

SIGNATURE of Patient or Legal Guardian *Date*

_____ _____

Patient's Name (please PRINT) *PRINT name of Legal Guardian*

NOTE: No revisions or changes to this form by you will be accepted

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Acknowledgment of Receipt of the Notice of Privacy Practices and Authorization regarding Protected Health Information

I give my consent for Revitalize Physical Therapy/Centers for Foot & Ankle Surgery, Ltd. to use and disclose **P**rotected **H**ealth **I**nformation (PHI) about me (or the patient I am legally responsible for) to carry out **T**reatment, **P**ayment, and Healthcare **O**perations (TPO).

With this consent, may call my home or other alternative location and leave a message on voice mail, in person, via text, or via email about any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls about my clinical care, including laboratory results, among others. With this consent, I may be contacted by mail or email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request how to restrict its uses or discloses my PHI to carry out TPO. Restriction requests must be made in writing; however, is not required to agree to my requested restrictions.

In the event Revitalize Physical Therapy is unable to contact me, I give full permission to contact the individuals I have designated below to disclose information pertinent to my case. This would include, but not be limited to information regarding pathology reports, laboratory tests, scheduling, and business information. By my signature below, I agree to hold harmless and waive any liability against Revitalize Physical Therapy/Centers for Foot & Ankle Surgery, Ltd. for the disclosure of information to the individual below.

_____ **(initial)** I authorize to contact me via text, voice, or email as provided by me

Name(s) of the person(s) I authorize the disclosure of my health / financial information:

Name_____Relationship_____Phone_____(_) Health (_) Financial

Name_____Relationship_____Phone_____(_) Health (_) Financial

I acknowledge I have been provided with or directed access to the Notice of Privacy Practices, a copy of which is also available in our lobby AND at www.FootAndAnkleCenters.com which provides a complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices before signing this consent.
We reserve the right to revise the Notice of Privacy Practices at any time.

I may revoke my consent in writing except to the extent has already made disclosures in reliance upon my prior consent.
If I do not sign this consent, or later revoke it, Revitalize Physical Therapy may decline to provide treatment to me.

_____ _____
SIGNATURE of Patient or Legal Guardian Date

_____ _____
Patient's Name (please PRINT) PRINT name of Legal Guardian Date

Office use only: This form will expire on:_____(7 years from today)

☐ Entered in notes **(Example:** HIPAA MAY RELEASE (H/F) TO PATRICK (spouse) -630-555-5555- OK TO LEAVE VM MSG- EXPIRES 01/01/31**)**

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